Behavioral Health Services
1575 Washington Street
Watertown, New York 13601

The documents included below are for the **Adult Intake Packet**. Please complete these documents to the best of your ability. You may complete these documents online or print them and bring them into the office. If a document does not apply to you, then leave it blank.

- ☐ Participants Rights
- ☐ Patient Registration
- ☐ Patient Consent Record
- ☐ Patient Attendance Attestation
- ☐ Outpatient Psychiatry Confirm Appointment Form
- ☐ Latex Allergy
- ☐ Privacy Practices Form
- ☐ Tele-Psych Consent Form
- ☐ Intake Questionnaire Adult
- ☐ GAD-7
- ☐ PHQ-9
- ☐ The Mood Disorder Questionnaire
- ☐ Fagerstorm Addiction Scale for Smokers
- ☐ Self-Evaluation Tobacco Use and Quitting
- ☐ SSI-AOD
- ☐ Vaping/JUULing Questionnaire
- ☐ Patient Packet – Health Care Proxy, DNR, Living Will, Bill of Rights
- ☐ Psychiatric Health Care Proxy

Should you have any questions, please call **Samaritan Behavioral Health at 315-779-5060**.

Samaritan Health
Behavioral Health Services
1575 Washington Street
Watertown, New York 13601
Phone: 315-779-5060 Fax: 315-779-5028

Participant's Rights

1. You have the right to an individualized treatment plan, and the right to participate in the establishment and revision of that plan to the fullest extent of your capacity.
2. You have the right to a full explanation of services provided in accordance with your treatment plan.
3. Participation in treatment in an outpatient program is voluntary. Recipients are presumed to have the capacity to consent to such treatment. The right to participate voluntarily and consent to treatment shall be limited only to the extent that:
    a. Section 330.20 of the Criminal Procedure Law and part 541 of the Codes Rules and Regulations of the New York State Office of Mental Health Provide for court ordered receipt of outpatient services;
    b. Article 81 of the Mental Hygiene Law provides for the surrogate consent of parent or guardian of a minor;
    c. Section 33.21 of the Mental Hygiene Law provides for the surrogate consent of a parent or guardian of a minor;
    d. A recipient enrolled in an assisted outpatient treatment program established pursuant to section 9.60 of the Mental Hygiene Law;
    e. A recipient engages in conduct which poses a risk of physical harm to self or others.
4. Your objection to or disagreement with any part of the treatment plan shall not, in and of itself, result in termination of services unless such objections renders your continued participation in the program clinically inappropriate or would endanger your safety or the safety of others.
5. The confidentiality of her clinical record shall be maintained in accordance with Section 33.13 of the Mental Hygiene Law.
6. You have access to your clinical record consistent with Section 33.16 of the Mental Hygiene law.
7. You have the right to receive clinically appropriate care and treatment suited to your needs, with is skillfully humanely administered with full respect for your dignity and personal integrity.
8. You have the right to receive services in such a manner that is non-discriminatory with respect to race, color, creed, disability, sex, age, national origin, sexual orientation, multiple diagnosis or diagnosis of HIV infection, AIDS or AIDS-related complex, the exception being that the Office of Mental Health regulations prevent us from serving a person with a primary diagnosis of alcohol or drug disorders, developmental disability, organic brain syndromes, or social conditions (V-codes).

9. You have the right to be treated in a way which acknowledges and respects your cultural environment.
10. You have the right to a maximum amount of privacy consistent with the affective delivery of services.
11. You have the right to freedom from abuse and mistreatment by employees of the program.
12. You have a right to file a grievance if you think that your rights herein have been violated, and the right to initiate questions, complaints or objections. All such concerns should be addressed with the staff involved with your treatment. If you think the issue has not been resolved you may submit your grievance, questions, complaints or objection in writing and dated to the Clinical Director, who will respond within ten (10) working days. If you still feel you grievance, questions, complaint or objection has not been adequately addressed, you should contact one or more of the following agencies or groups:

New York State Office of Mental Health
44 Holland Ave.
Albany, NY 12229
Phone: 800-597-8481

New York State Office of Mental Health
CNY Field Office
545 Cedar Street
Syracuse, NY 13201
Phone: 315-426-3942

Commission on Quality of Care for Mentally Disabled
401 State Street
Schenectady, NY 12305-2397
Phone: 800-624-4143

The Alliance for the Mentally Ill of New York State
260 Washington Avenue
Albany, NY 12210
Phone: 518-462-2000

Northern Regional Center for Independent Living
210 Court Street
Watertown, NY 13601
Phone: 315-785-8703 or 877-785-8704

Joint Commission
1-800-994-6610

New York State Justice Center
1-855-373-2122

Samaritan
Medical Center
Watertown, NY

DATE _____

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Male or Female: _____ Marital Status: _____

State in Which You Were Born _____

Street Address: _____

Alternate Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Social Security #: _____

May We Call You at Home? Yes ☐ No ☐ May We Leave a Message? Yes ☐ No ☐

EMPLOYER

Employer's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone Number: _____ Occupation: _____

May We Call You at Work? Yes ☐ No ☐ May We Leave a Message? Yes ☐ No ☐

NEXT OF KIN

Name: _____ Relationship to the Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name: _____ Relationship to the Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

GUARANTOR (PERSON FINANCIALLY RESPONSIBLE FOR THE PATIENT)

Name: _____ Relationship to the Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Social Security #: _____

Employer: _____ Occupation: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number _____

INSURANCE

DOES YOUR INSURANCE REQUIRE PRE-AUTHORIZATION PRIOR TO THIS OFFICE VISIT?
YES _____ NO _____

PRIMARY INSURANCE COMPANY: _____ Phone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Policy #: _____ Group#: _____ Subscriber Name _____

Subscriber Date of Birth _____ Soc Sec # _____Relationship to Patient: _____

SECONDARY INSURANCE COMPANY: _____ Phone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Policy #: _____ Group#: _____ Subscriber Name _____

Subscriber Date of Birth _____ Soc Sec # _____Relationship to Patient: _____

OTHER INSURANCE COMPANY: _____ Phone #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Policy #: _____ Group#: _____ Subscriber Name _____

Subscriber Date of Birth _____ Soc Sec # _____Relationship to Patient: _____

Samaritan
Family Health Center
Watertown, NY

PATIENT CONSENT RECORD

Patient Name: _____ Date of Birth: _____

**Patient identifiers utilized to confirm above.

Consent for Treatment

I hereby authorize the Samaritan Family Health Network and its representatives to conduct any diagnostic, routine, or emergency examination, tests, and procedures, to obtain specimens from myself, or a minor child if signed by a Representative, and to provide any medications, treatment or therapy as it is now deemed or as it may be deemed on subsequent visits. I understand that it is the responsibility of my provider to explain to me the reasons for any examination, test, or procedure, the available treatment options, alternative courses of treatment, the common risks and the anticipated benefits, and the risks associated with declining care.

☐ **YES**, I give my consent to treatment. ☐ **NO**, I do not give my consent to treatment.

Permission to Disclose to Family/Other Individuals

You may authorize the Samaritan Family Health Network and its representatives to disclose your protected health information to family members or other individuals in order to assist with your continuing care.

☐ **YES**, I give permission to disclose my protected health information to the following family members and individuals:

Date of Permission	Name of Individual	Relationship

☐ **NO**, I do not give permission to disclose my protected health information to family or other individual.

Have you completed any of the following Advance Directives?

Please check all that apply. If checked, please provide us with a copy.

☐ I have a **LIVING WILL**
☐ I have a **NON-HOSPITAL DNR**
☐ I have a **POWER OF ATTORNEY**
☐ I have a **HEALTH CARE PROXY**
☐ I have a **MOLST** form

Name of Health Care Proxy:_____ Phone Number:_____

Acknowledgment of Understanding

☐ **YES**, I have received a copy of the **Patients' Bill of Rights**, and information relative to **Advance Directives** including **New York State Health Care Proxy** information. I have had an opportunity to ask any questions I may have pertaining to these materials.

Authorization to Process Claims and Release Information

Samaritan
Family Health Center
Watertown, NY

PATIENT CONSENT RECORD

☐ **YES**, I authorize Samaritan Family Health Network and its representative to release any information they obtain, including medical information, to my Insurance Company or to their representatives, to process claims for payment.

Guarantee of Payment and Authorization of Benefits

☐ **YES,** I agree to assign and transfer to the Samaritan Family Health Network all benefits and payments due and payable or to become due and payable to me under any insurance policy, self-insurance program, third-party action, or any other benefit plan program for as long as I receive services from the Samaritan Family Health Network.

☐ **YES**, I understand that this assignment does not relieve me of my financial responsibility for all charges incurred. I also accept financial responsibility for charges not directly reimbursed to the Samaritan Family Health Network. Furthermore, I agree to pay all costs incurred for collection and reinforcement of this payment obligation.

My signature confirms I have been given an opportunity to review this form for accurateness, ask questions, and all of my questions have been answered fully and satisfactorily.

_____ _____
Signature Date

_____
Relationship to Patient

I attest that the patient has no further questions and has electronically signed this form.

_____ _____ _____
Witness (name) Date Time

Samaritan Health

Outpatient Behavioral Health Services
1575 Washington Street
Watertown, New York 13601

sticker:

Patient Attendance Attestation

Samaritan Medical Center Outpatient Behavioral Health Services providers are dedicated to ensuring that your mental health care needs are met in a quality setting. We make every effort to schedule your visit at a time that is convenient to you. Unfortunately, many patients do not keep their appointments and do not notify the office 24 hours in advance to cancel or reschedule. We make every attempt to respond to referrals as quickly as possible. To help prevent the growth of a large waiting list and to assist others in receiving services in a timely manner, patients are expected to make every effort to keep all scheduled appointments and be compliant with treatment recommendations.

Your case may be closed if you demonstrate a pattern of non-compliance with any of the following:

- **Missed Appointments (Defined as not keeping any previously-scheduled appointment (including psychotherapy and psychiatric appointments) and does not notify the clinic more than 24 hours prior to the scheduled appointment time):**
  - **If you miss two (2) consecutive appointments.**
  - **If you miss four (4) appointments within a 3-month period**.
  - **If you demonstrate a pattern of repeated cancellations and rescheduling of appointments (even with more than 24 hours of advance notice).**
  - **If you present late for an appointment. It would be up to the provider at that date and time to decide if the appointment can be kept or if it would be necessary to reschedule.**

- **Non-compliance with treatment recommendations**

If there are occasions when you must cancel or reschedule an appointment, please make every attempt to contact the clinic office at least 24 hours in advance of your appointment, in order that patients may be scheduled during that time slot. Please note that legitimate extenuating circumstances such as inclement weather, medical emergencies, etc. will be taken into consideration.

If you have any questions regarding this policy please refer them to your clinician or to the Clinical Director. Please sign below to indicate that you have read and understand the new policy.

Signature:_____ Date:_____

Samaritan Health
Behavioral Health Services
1575 Washington Street
Watertown, New York 13601
Phone: 315-779-5060
Fax: 315-779-5028

OUTPATIENT PSYCHIATRY CONFIRM APPOINTMENT FORM

May we confirm your scheduled appointment time by leave a message on your answering machine or you personally?

YES ☐ NO ☐

Print Name: _____ DOB: _____

SS#: _____

Signature: _____ Date: _____

Witness: _____Date: _____

MR-401 Approved 07/02

Samaritan
Medical Center
Watertown, NY

LATEX ALLERGY QUESTIONNAIRE

Questions to ask of inpatients, outpatients,
and employees of Samaritan Health

Place patient identification
sticker here

LATEX ALLERGY

1. Have you ever developed any type of reaction after handling latex products such as rubber gloves, condoms, diaphragms, balloons, socks, or underwear? ☐ Yes ■ No

   Comments: _____

   _____

2. Have you ever developed any type of reaction during or after a dental appointment, vaginal/rectal examination, surgical procedure, or other exposure to rubber gloves? ☐ Yes ☐ No

   Comments: _____

   _____

LATEX RISK

3. Have you ever had any difficulty breathing or hives after eating or handling any fruits or vegetables such as kiwi, bananas, stone fruits, or chestnuts? ☐ Yes ☐ No

   Comments: _____

   _____

4. Do you have a previous personal history of more than nine surgeries, spina bifida, or repeated catheterizations? ☐ Yes ■ No

   Comments: _____

   _____

5. Are you frequently exposed to latex products in your occupation? ☐ Yes ☐ No

RECORD ALLERGY OR RISK IN CHART UNDER "ALLERGIES"

_____ _____

Signature of Patient or Employee Date:

Assessment/Comments: _____

_____

_____

_____

_____

Samaritan

ACKNOWLEDGEMENT & SUMMARY
of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

We, at Samaritan, pledge to give you the highest quality health care and to have a relationship with you that is built on trust. This trust includes our commitment to respect the privacy and confidentiality of your health information.

This Notice is being given to you because federal law gives you the right to be told ahead of time about:

- how Samaritan will handle your medical information
- Samaritan's legal duties related to your medical information
- your rights with regard to your medical information.

When you need care, Samaritan gathers information about you necessary to provide that care and uses this information within the health system and shares the information outside the system to continue to provide you excellent care. Samaritan is obligated to protect your information in a manner consistent with the laws designed to uphold the privacy and confidentiality of your health information. You have certain rights regarding your information that is contained in Samaritan's records, such as the right to request restrictions on the uses of your information and the right to request access to and a copy of your health information. This brief notice is a summary only. A comprehensive notice is attached to this page.

I acknowledge that I have been provided a copy of SAMARITAN's Notice of Privacy Practices.

Print Name	Patient's Signature	Date
Print Name	Patient's Authorized Representative (If Applicable)	Date

---

For SAMARITAN Use Only

Good faith efforts were made to obtain the above-written acknowledgement as follows:

The reason(s) the patient's/authorized representative's acknowledgement was not obtained is as follows:

Documented By:

Print Name and Title	Signature	Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I. SAMARITAN

This Notice of Privacy Practices (the "Notice") applies to information and records regarding your health care maintained by Samaritan. This Notice will be followed by the several components of Samaritan Medical Center including the Hospital, Samaritan Family Health Centers located in Jefferson and Oswego Counties, Samaritan-Keep Nursing Home, and Samaritan Summit Village. (Collectively "SAMARITAN"). All healthcare professionals authorized to enter information into your medical record and independent health care providers involved in your care while practicing at Samaritan will follow this notice. Residents, students and graduate students of health care professional schools affiliated with SAMARITAN and any volunteer we allow to help you while you are a SAMARITAN patient/resident, and independent contractors, must follow the privacy practices described in this Notice as well.

II. OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

SAMARITAN is committed to protecting your medical information. We create a record of the care and services you receive at SAMARITAN for use in your care and treatment. This notice applies to all of the records of your care generated by Samaritan, whether made by Samaritan personnel, your personal doctor or other healthcare professionals. Samaritan does not assume any liability for any negligence or professional malpractice committed by the independent health care providers covered under this Notice. Physician practices not owned by Samaritan may have different policies or notices regarding the doctor's use and disclosure of your protected health information created in the doctor's office or clinic. This Notice tells you about the ways in which we may use and disclose your medical information. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to:

- make sure that your medical information is protected;
- give you this Notice describing our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the Notice that is currently in effect.
- Notify you of a breach of unsecured protected health information.

If you have any questions regarding this Notice, please call SAMARITAN's Privacy Officer at (315) 779-5186.

III. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following describes how we may use and disclose your health information for treatment, payment and healthcare operations. Not every type of use or disclosure is listed below, but the ways in which we use or disclose your information will be under one of these purposes. In addition, depending on the nature of the health information, such as HIV-related, genetic, and mental health information, we may be subject to stricter use and disclosure requirements under state law. We shall follow such requirements.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, students, or other personnel who are involved in your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the hospital's food service if you have diabetes so that we can arrange for appropriate meals. We may also share medical information about you with other SAMARITAN personnel or non-SAMARITAN providers, agencies or facilities in order to provide or coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside SAMARITAN who may be involved in your continuing medical care after discharge such as other health care providers, transport companies, community agencies and family members.

For Payment: We may use and disclose your medical information so that the treatment and services you receive at SAMARITAN or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your information to your health plan about surgery you received at SAMARITAN so your health plan will reimburse you or pay us for the service. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose medical information about you for SAMARITAN operations. These uses and disclosures are made for quality of care and medical staff activities, health sciences education within SAMARITAN, and teaching programs with our affiliates. In addition, your medical information may also be used or disclosed to comply with law and regulations, for contractual obligations, patients' claims, grievances, lawsuits, health care contracting, legal services, business planning and development, business management and administration, and underwriting and other insurance activities. We may also disclose information to doctors, nurses, technicians, medical and other students, and other personnel for performance improvement and educational purposes.

IV. USES AND DISCLOSURES OF INFORMATION IN SPECIAL SITUATIONS

We may use or disclose your health information in certain special situations as described below, without authorization, to the extent such uses and disclosures comply with federal and state law.

Appointment Reminders: We may contact you to remind you that you have an appointment at SAMARITAN. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will make every attempt to accommodate all reasonable requests. In addition, we may use sign in sheets to enhance patient flow processes.

Treatment Alternatives: We may tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may contact you to tell you about benefits or services that may be of interest to you.

Fundraising Activities: We, or Samaritan Foundation of Northern New York may contact you to provide information about SAMARITAN sponsored activities, including fundraising programs and events. In these instances, we only use contact information, such as your name, address and phone number and the dates you received treatment or services at SAMARITAN. You have the right to request that we not contact you for subsequent fundraising events.

News Gathering Activities: We may contact you or a family member when a news reporter has requested an interview with you. News reporters often seek interviews with patients injured in accidents or experiencing particular medical conditions or procedures. For example, a reporter working on a story about a new cancer therapy may ask whether any of the patients undergoing that therapy might be willing to be interviewed. In such cases, a member of our staff would contact you to discuss whether or not you want to participate in the story. If you choose to participate in the interview, the staff member will obtain your written authorization to do so, and a copy of this authorization will be kept in your medical record.

Hospital Directory: If you are hospitalized, we may include certain limited information about you in the hospital directory. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. This information may include your name, location in the hospital, your general condition (e.g., fair, critical, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may only be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy even if they don't ask for you by name. You may restrict or prohibit the use or disclosure of this information by notifying SAMARITAN's Patient Registration Department at (315) 785-4095.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give your medical information to someone who helps pay for your care. We may also tell your family or friends about your general condition and that you are in the hospital. We also may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Disaster Relief Efforts: We may disclose your medical information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
As Required By Law: We will disclose medical information about you when required to do so by federal or state law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Organ and Tissue Donation: We may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation.

Workers Compensation: We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness

Cancer Registry: If you have a newly diagnosed cancer, we will release your medical information to the New York State Cancer Registry.

Military and Veterans: If you are or were a member of the Armed Forces, we may release medical information about you to military command authorities as authorized or required by law. We may also release medical information about foreign military personnel to the appropriate military authority as authorized or required by law.
Workers' Compensation: We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Public Health & Safety: As required by law, we may disclose medical information about you for public health purposes. These purposes generally include the following:

- preventing or controlling disease, injury or disability;
- reporting vital events such as births and deaths;
- reporting suspected child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- notifying the appropriate government authority if we suspect a patient has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

Health Oversight Activities: We may disclose your medical information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Actions: In connection with lawsuits or other legal proceedings, we may, as authorized or required by law, disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement: If asked to do so by law enforcement, and as authorized or required by law, we may release your medical information:

- to identify or locate a suspect, fugitive, witness, or missing person;
- about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death suspected to be the result of criminal conduct;
- about alleged criminal conduct at SAMARITAN; and
- in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: In most circumstances, we may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. We may also disclose your medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized or required by law.

Protective Services for the President and Others: As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President of the United States, other authorized persons or foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

Incidental Uses and Disclosures: In order to ensure that communications essential to providing quality healthcare would not be hindered, incidental disclosures may occur. An example of this would be another person overhearing a confidential communication between providers at a nurse's station in the emergency room.

V. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Your medical record is the property of SAMARITAN. You have the following rights, however, regarding medical information we maintain about you:

Right to Inspect and Copy: With certain exceptions, you have the right to inspect and/or receive a copy of your medical information. To inspect and/or to receive a copy of your medical information, you must submit your request in writing to SAMARITAN's Health Information Management Department at 830 Washington Street, Watertown, New York 13601. If you

request a copy of the information, there is a fee for these services. The fee may be waived in certain circumstances. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to your medical information, you may request an appeal of such denial through the New York State Department of Health. Contact Samaritan's Health Information Management Department at (315)785-4198 to obtain a special Department of Health form to request such an appeal. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

Right to Request an Amendment: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend your medical information. You have the right to request an amendment for as long as the information is kept by or for SAMARITAN.
To request an amendment, your request must be made in writing and submitted to SAMARITAN's Health Information Management Department. In addition, you must provide a reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

- was not created by SAMARITAN;
- is not part of the medical information kept by or for SAMARITAN;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete in the record.

Right to an Accounting of Disclosures: You have the right to receive a list of the disclosures we have made of your medical information unless the disclosure was for treatment, payment, health care operations or if you authorized in writing the disclosure of your health information. Certain other disclosures are not included in the list, including disclosures you authorized us to make; disclosures to the facility directory; disclosures made to you, or to your family and friends involved in your care; disclosures made to federal officials for national security purposes; disclosures made to correctional facilities; and disclosures made six years prior to your request. To request this accounting of disclosures, you must submit your request in writing to SAMARITAN's Health Information Management Department. Your request must state a time period that may not be longer than the six previous years and may not include dates before April 14, 2003. SAMARITAN will provide you one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. You also have the right to restrict the disclosure of your health information to a health plan (your health insurer) related to services or items we provide to you and you pay us for such services or items we provide to you and you pay us for such services or items out-of-pocket in full, we must agree to your request, unless we are required by law to disclose the information. Please note: This restriction will apply only when requested and services are paid in full. Future services without a restriction request and for which no out-of-pocket payment is received will be billed per provider and health plan policy, which may include current provider notes that reference prior treatments or services previously restricted. To request a restriction, you must make your request in writing to SAMARITAN's Health Information Management Department. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail. To request confidential communications, you must make your request in writing to SAMARITAN's Health Information Management Department. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. Copies of this Notice shall be available throughout SAMARITAN, or you may obtain a copy at our website, www.samaritanhealth.com

VI. CHANGES TO SAMARITAN'S PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change SAMARITAN's privacy practices and this Notice. We reserve the right to make the revised Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice physically at various locations at SAMARITAN and electronically on the website. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, you may request a copy of the current Notice in effect.

VII. QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact SAMARITAN's Health Information Management Department at (315) 785-4198. If you believe your privacy rights have been violated, you may file a complaint with SAMARITAN or with the Secretary of the United States Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201. To file a complaint with SAMARITAN, contact the Privacy Officer, telephone number (315) 779-5186. For an anonymous complaint reporting, call 877-740-7070 or (315) 779-5170. You will not be penalized for filing a complaint.

VIII. USES AND DISCLOSURES REQUIRING WRITTEN AUTHORIZATION

We will only make the following uses and disclosures with your written authorization:

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute a sale of protected health information.
- Most uses and disclosures of psychotherapy notes.

IX. OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of your medical information not covered by this Notice will be made only with your written authorization. In those instances where your prior written permission for the use and disclosure of your health information is necessary, we will provide you with SAMARITAN's Authorization Form for you to sign. You may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

Samaritan Health
Behavioral Health Services
1575 Washington Street
Watertown, New York 13601

Telepsych Consent Form

I _____ (Patient) hereby consent to engaging in telepsych at Samaritan Medical Center Behavioral Health and Addiction Services as part of my treatment. I understand that "telepsych" includes the practice of health care delivery, assessment, diagnosis, consultation, psychotherapy and psychiatric treatment using interactive audio/video through secure webcam and/or phone communications.

☐ **Technology:** I understand that I will need to download an application and/or software called "Zoom" to use this platform. I also need to have broadband internet connection or a smart phone device with good cellular connection at home or at a location deemed appropriate for services. I also understand that in case of technology failure, I may contact Samaritan Behavioral Health and Addiction Services via phone to coordinate alternative methods of treatment.

Video/Audio Recording: As a general practice, we DO NOT record telepsych sessions.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telepsych. Telepsych platform is HIPAA compliant to protect my privacy and confidentiality.

I understand that I have the right to withdraw my consent at any time.

_____ _____
Patient Signature Date

_____ _____
Patient Guardian Signature Date

_____ _____
Employee Signature Date

Samaritan Health
Behavioral Health Services
1575 Washington Street
Watertown, New York 13601
Ph: 315-779-5060

INTAKE QUESTIONNAIRE- ADULT

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Date:_____

IDENTIFYING INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Gender: _____

_____ Work Phone (indicate whose #):

Home Phone: (_____)_____ (_____)_____

Cell Phone: (_____)_____

Social Security Number:_____

Language of Choice:

☐ English ☐ Spanish

☐ Other: _____

Sex Assigned at Birth	Gender	Sexual Orientation
☐ **Male**	☐ Woman/Girl	☐ Lesbian
	☐ Transgender Woman/Girl	☐ Bisexual
☐ **Female**	☐ Man/Boy	☐ Gay
	☐ Transgender Man/Boy	☐ Pansexual
☐ **Intersex**	☐ Non-Binary Person	☐ Asexual
	☐ Gender Non-Conforming	☐ Straight/Heterosexual
	☐ Not Sure/Questioning	☐ Queer
		☐ Not Sure/Questioning
	Other _____	Other _____

DISABILITY

1. If you have a disability, does the office need to accommodate your needs? ☐ Yes ■ No

If yes, please explain:

_____

_____

PRESENTING PROBLEM (current situation and history)

1. In your own words, please describe the current problems as you see them:

_____

_____

_____

_____

2. How long has this been going on?

_____

_____

3. What made you come in at this time?

_____

_____

_____

4. What would you like to see different as a result of your treatment?

_____

_____

_____

_____

MEDICAL HISTORY

1. Primary Care physician: _____

2. Date of last examination: _____

3. Date of last eye exam: _____

4. Current Pharmacy: _____ Location: _____

5. Do you have a therapist? ☐ Yes ☐ No Who: _____

6. Do you have a case manager? ☐ Yes ☐ No Who: _____

7. What agency is the case manager from? _____

8. Current medical status:

Diabetes	☐ Yes	☐ No
Elevated Cholesterol	☐ Yes	☐ No
Coronary artery Disease	☐ Yes	☐ No
Are you overweight?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No

9. Are you currently in treatment for any medical condition?

_____

_____

10. Please provide information about current medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

11. Please provide information about previous medication(s), prescription or over-the-counter, you have taken in the past:

Medication		Prescribing	For what	Response to medication

12. Herbal Preparations (check all that you use)

☐ St. John's Wart ☐ Melatonin ☐ Gingko Biloba

☐ Valerian ☐ Kava Kava ☐ Ginseng

☐ Ma Huang ☐ Other: _____

13. Over the counter, non-prescription medications including sleep aids and pain meds (check all that you use)

☐ Aspirin ☐ Benadryl ☐ Tylenol

☐ Pseudafed ☐ Motrin ☐ Other: _____

☐ Other: _____

14. Are you allergic to any medications? ☐ Yes ☐ No

Medication	Reaction

15. Please **check** any symptoms or experiences that you have had **in the last month**

☐ Difficulty falling asleep ☐ Difficulty staying asleep

☐ Difficulty getting out of bed ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

☐ Persistent loss of interest in previously enjoyed activities

☐ Withdrawing from other people ☐ Spending increased time alone

☐ Depressed Mood ☐ Feeling Numb

☐ Rapid mood changes ☐ Irritability

☐ Anxiety ☐ Panic attacks

☐ Frequent feelings of guilt ☐ Avoiding people, places, activities or specific things

☐ Difficulty leaving your home

☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____

☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)Describe: _____

☐ Outbursts of anger ☐ Fear Feeling or acting like a different person

☐ Hopelessness ☐ Worthlessness

☐ Sadness ☐ Helplessness

☐ Changes in eating/appetite ☐ Eating more/ Eating less

☐ Voluntary vomiting ☐ Use of laxatives

☐ Excessive exercise to avoid weight gain ☐ Binge eating

Are you trying to lose weight? YES NO

Weight gain: _____ lbs. Weight loss: _____ lbs.

☐ Difficulty catching your breath ☐ Increase muscle tension

☐ Unusual sweating ☐ Easily started, feeling "jumpy"

☐ Increased energy ☐ Decreased energy

☐ Tremor ☐ Dizziness

☐ Frequent worry ☐ Physical sensations others don't have

☐ Racing thoughts ☐ Intrusive memories

☐ Difficulty concentrating or thinking ☐ Large gaps in memory

☐ Flashbacks ☐ Nightmares

☐ Thoughts about harming or killing yourself ☐ Thoughts about harming or killing someone else

☐ Difficulty problem solving ☐ Difficulty meeting role expectations

☐ Dependency on others ☐ Manipulation of others to fulfill your own desires

☐ Inappropriate expression of anger ☐ Self-mutilation/cutting

☐ Difficulty or inability to say "no" to others ☐ Ineffective communication

☐ Sense of lack of control ☐ Decreased ability to handle stress

☐ Abusive relationship ☐ Difficulty expression emotions

☐ Feeling as if you were outside yourself, detached, observing what you are doing

☐ Feeling puzzled as to what is real and unreal

☐ Persistent, repetitive, intrusive thoughts, impulses, or images

☐ Unusual visual experiences such as flashes of light, shadows

☐ Hear voices when no one else is present

☐ Feeling that your thoughts are controlled or placed in your mind

☐ Feeling that the television or the radio is communicating with you

16. Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

17. Do you have?

A cough lasting 3 or more weeks that may produce discolored, bloody sputum ☐ Yes ☐ No

☐ Unintended weight loss ☐ Fatigue ☐ Slight fever

☐ Night Sweats ☐ Chills ☐ Loss of appetite

☐ Positive TB test, if yes which meds were you given: _____

Did you complete the treatment for TB? ☐ Yes ☐ No

18. Childhood Illnesses

☐ Measles	☐ Meningitis	☐ Mumps
☐ Rheumatic Fever	☐ Chicken Pox	☐ Other: _____

19. Please check the appropriate box if you have experienced any of these problems:

☐ Eye disease, injury, poor vision	☐ Itchy Eyes	☐ Excessive tearing
☐ Vision change	☐ Glasses/ Contacts	☐ Hearing loss
☐ Discharge from ears	☐ Imbalance	☐ Hearing Aid
☐ Ear Infections	☐ Nose Bleeding	☐ Nasal Discharge/ Runny
☐ Nose Obstruction	☐ Loss of Smell	☐ Sinus problems/ infections
☐ Allergies or asthma	☐ Dental Problems	☐ Mouth Sores/ ulcers
☐ Altered Taste	☐ Throat Pain	☐ Difficulty Swallowing
☐ Hoarseness	☐ Neck Soreness/ Stiffness/ Pain	☐ Lumps/ swelling in neck
☐ Circulatory problems	☐ Pain Urinating	☐ Frequent Urination
☐ Bowel problems	☐ Hemorrhoids, rectal bleeding	☐ Head injury
☐ Loss of consciousness	☐ Convulsions or seizures	☐ Frequent or severe headaches
☐ Memory problems	☐ Sleep disturbances	☐ Extreme tiredness or weakness
☐ Marked weight changes	☐ Skin disease	☐ High blood pressure
☐ Heart disease	☐ Heart Murmur	☐ Back, arm, leg or joint problems
☐ Blood disease	☐ Cancer	☐ Diabetes
☐ Encephalitis	☐ Stomach problems	☐ Reflux
☐ Meningitis	☐ Liver, gallbladder disease	☐ Thyroid disease or goiter
☐ Pregnancy	☐ Premenstrual Syndrome (PMS)	☐ Eating disorder
☐ Jaundice	☐ Hepatitis	☐ Cirrhosis
☐ Glaucoma	☐ Cataract	☐ Hypertension
☐ COPD	☐ Sleep apnea	☐ Emphysema
☐ Concussion	☐ Coma	☐ Stroke
☐ Kidney Failure	☐ Kidney Stone	☐ Gastric bypass
☐ Hyperthyroid	☐ Hypothyroid	☐ Cardiac bypass
☐ Heart attack	☐ Congestive Heart Failure	☐ Other _____
☐ Difficulty hearing	☐ Recent Falls	

20. Please explain anything checked above: _____

_____

21. List any prior illnesses, accidents, medical hospitalizations:

_____

_____

20. Please list all operations you have had including the approximate date:

_____

_____

_____

_____

21. Pain Assessment

Do you current have pain? ☐ Yes ☐ No

if yes, where _____

Cause of pain_____

Pain is: ☐ Constant ☐ Intermittent ☐ Burning ☐ Stabbing

What makes the pain worse: _____

Rate you pain 0-10 (0 is no pain, 10 is the worst pain you can imagine) _____

Is your pain being treated? ☐ Yes ☐ No

If yes, by whom: _____

22. Do any immediate family members have any major medical problems? (check all that apply)

☐ Diabetes Who:_____

☐ Elevated Cholesterol Who: _____

☐ Elevated Triglycerides Who: _____

☐ Coronary Artery Disease Who: _____

☐ Bleeding disorder Who: _____

☐ Heart Disease Who: _____

☐ High Blood Pressure Who: _____

☐ Cancer Who: _____

☐ Stroke Who: _____

☐ Other Please explain: _____

FAMILY HISTORY

1. ***Mother:***

☐ Living Age: _____

☐Deceased, Cause of death: _____

If deceased, HER age at time of her death: _____

YOUR age at time of her death: _____

Occupation: _____

Health: _____

Frequency of contact with her: _____

Are you/Have you been close to her? ☐ Yes ☐ No

2. ***Father:***

☐ Living Age: _____

☐Deceased, Cause of death: _____

If deceased, HIS age at time of HIS death: _____

YOUR age at time of his death: _____

Occupation: _____

Health: _____

Frequency of contact with him: _____

Are you/Have you been close to him? ☐ Yes ☐ No

3. ***Siblings***

Name	Age	Sex	Whereabouts?	Are you close to him/ her?

4. During your childhood had you ever lived outside of the parental home (e.g. foster care; with relatives; in a group home)? ☐ Yes ☐ No

If yes, please indicate the placements and dates: _____

_____

Are there any other circumstances you would like us to be aware of?

_____

_____

_____

_____

_____

THERAPIST REVIEW

Signature: _____ Date: _____

NURSE REVIEW

Signature: _____ Date: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☑	☐	☐	☐
2. Not being able to stop or control worrying	☑	☐	☐	☐
3. Worrying too much about different things	☑	☐	☐	☐
4. Trouble relaxing	☑	☐	☐	☐
5. Being so restless that it's hard to sit still	☑	☐	☐	☐
6. Becoming easily annoyed or irritable	☑	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐
Somewhat difficult ☐
Very difficult ☐
Extremely difficult ☐

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	☑	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself	☐	☐	☐	☐
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

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A2663B 10-04-2005

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

◉ No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

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QUIT QUIT USING AND INHALING TOBACCO

Fagerstrom Tolerance Scale

Print Form

Name _____ Date _____

Write the number of the answer that is most applicable in the box to the right of the question.

1. How soon after you wake do you smoke your first cigarette?

After 60 minutes = **0** ☐ 31-60 minutes = **1** ☐ 6–30 minutes = **2** ☐ within 5 minutes = **3** ☐ _____

2. Do you find it difficult to refrain from smoking in places where it is forbidden, such as the library, theatre or doctors' office?

No = **0** ☐ Yes = **1** ☐ _____

3. Which cigarette would you hate most to give up?

The first one in the morning = **1** ☐ All others = **0** ☐ _____

4. How many cigarettes per day do you smoke?

10 or less = **0** ☐ 11–20 = **1** ☐ 21–30 = **2** ☐ 31 or more = **3** ☐ _____

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?

No = **0** ☐ Yes = **1** ☐ _____

6. Do you smoke even if you are so ill that you are in bed most of the day?

No = **0** ☐ Yes = **1** ☐ _____

SCORING INSTRUCTIONS: Add up your responses to all the items. **TOTAL SCORE** _____

Dependence Scores: 0–2 Very low 3–4 Low 5 Medium 6–7 High 8–10 Very High

Reference

Heatherton, T.F., Kozlowski, L.T., Frecker, R.C., Fagerstrom, K.O. (1991). The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire. *British Journal of Addictions, 86,* 1119–1127.

Heart and Stroke Foundation. The Fagerstrom Test for Nicotine Dependence. Available at http://ww2.heartandstroke.ca/DownloadDocs/PDF/Fagerstrom_Test.pdf. Accessed August 21, 2007

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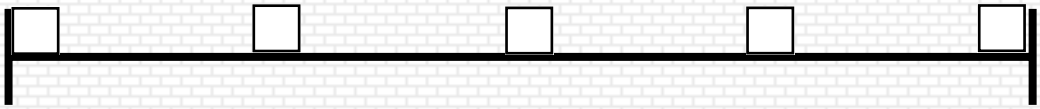
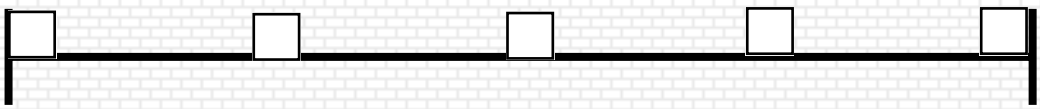
SELF EVALUATION
Tobacco Use & Quitting

Please mark the spot that reflects how *important* it is for you to change your tobacco use.



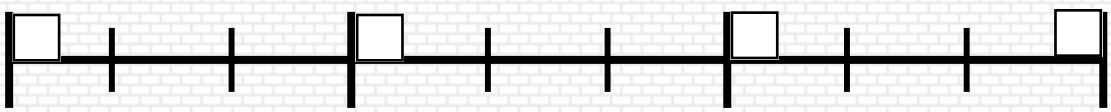
Not Important **Very Important**

Please mark the point that reflects how *confident* you are that you can change your tobacco usage.



Not Confident **Very Confident**

On the following scale, which point best describes how ready you are at this time to change your tobacco habit?



Not At All Ready To Change Tobacco Use

Thinking About Changing My Smoking/Dipping

Planning & Making A Commitment To Change My Smoking/ Dipping

Actually Changing My Smoking/ Dipping

Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

Patient Name: _____ **Date:** _____

During the past 6 months:

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) ..... Please Select
2. Have you felt that you use too much alcohol or other drugs? ..... Please Select
3. Have you tried to cut down or quit drinking or using drugs? ..... Please Select
4. Have you gone to anyone for help because of your drinking or drug use? (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program) ... Please Select
5. Have you had any of the following?
   Put a check mark next to any problems you have experienced.
   - ○ Blackouts or other periods of memory loss?
   - ○ Injury to your head after drinking or using drugs?
   - ○ Convulsions or delirium tremens (DTs)?
   - ○ Hepatitis or other liver problems?
   - ○ Felt sick, shaky, or depressed when you stopped drinking or using drugs?
   - ○ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ○ Injury after drinking or using?
   - ○ Used needles to shoot drugs?

   Circle "yes" if at least one of the eight items above is checked ..... Please Select
6. Has drinking or other drug use caused problems between you and your family or friends? ..... Please Select
7. Has your drinking or other drug use caused problems at school or at work? ..... Please Select
8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession) ..... Please Select
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? ..... Please Select
10. Do you need to drink or use drugs more and more to get the effect you want? ..... Please Select
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? ..... Please Select
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? ..... Please Select
13. Do you feel bad or guilty about your drinking or drug use? ..... Please Select

continued on other side

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The next questions are about lifetime experiences.

14. Have you ever had a drinking or other drug problem? Please Select

15. Have any of your family members ever had a drinking or drug problem? Please Select

16. Do you feel that you have a drinking or drug problem now? Please Select

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Vaping/JUULing Questionnaire

1. Do you currently vape/JUUL?
   - ☐ Yes
   - ☐ No

2. If you vape, what type of device are you using?
   - ☐ JUUL
   - ☐ Vape Wear
   - ☐ Home-made device
   - ☐ Other electronic cigarettes

3. If yes, how soon after you wake in the morning do you first vape/JUUL?
   - ☐ Within 30 minutes
   - ☐ More than 30 minutes

4. Do you vape/JUUL more in the morning than the rest of the day?
   - ☐ Yes
   - ☐ No

5. Have you ever vaped MJ products in your device?
   - ☐ Yes
   - ☐ No

6. Do you smoke/chew and vape/JUUL on the same day?
   - ☐ Yes
   - ☐ No

7. Do you find that it is more satisfying to vape/JUUL first thing in the morning?
   - ☐ Yes
   - ☐ No

8. Do you find it difficult to not vape/JUUL in areas where it is forbidden?
   - ☐ Yes
   - ☐ No

9. Do you vape/JUUL when you are sick enough to have to stay in bed?
   - ☐ Yes
   - ☐ No

10. Do you believe that vaping/JUULing is harmful to your health?
    - ☐ Yes
    - ☐ No

11. How many pods do you use?
    - ☐ One pod every two weeks
    - ☐ One pod a week
    - ☐ One pod a day
    - ☐ More than one pod a day

12. Have you experienced any changes to your health since you started vaping?
    - ☐ No, I have not noticed any changes to my health
    - ☐ No, my health has stayed the same
    - ☐ Yes, my health has improved
    - ☐ Yes, my health has declined

13. Are you interested in quitting vaping/JUULing?
    - ☐ Yes
    - ☐ No

14. Have you ever tried to stop vaping?
    - ☐ Yes
    - ☐ No